

INCIDENT REPORT FORM

***FOR USE BY DHS CONTRACTED/LICENSED PROVIDERS ONLY; DHS STAFF TO USE IRIS**

Information to be typed whenever possible; Otherwise, clearly PRINT

- Please check appropriate boxes and complete all applicable blanks
- Use designated space on back of form for additional information as necessary

Type of Report

<input type="checkbox"/> Initial Written	Date/Time _____
<input type="checkbox"/> Follow-up	Date _____
<input type="checkbox"/> Final	Date _____

TO

Name of Division Director/Designee

Division

FROM

Name of Person Submitting Report

Provider/Program Name

Telephone

Type of Service/Program

(i.e., Mental Health, DD program, Day Treatment, Residential, etc.)

1) OTHER NOTIFICATIONS Enter method, date & time communicated when appropriate

<input type="checkbox"/> Adult Protective Services Hotline (1-800-482-8049).....	_____
<input type="checkbox"/> Child Abuse Hotline (1-800-482-5964).....	_____
<input type="checkbox"/> DHS Client Advocate.....	_____
<input type="checkbox"/> DHS Communications Director	_____
<input type="checkbox"/> DHS Office of Chief Counsel.....	_____
<input type="checkbox"/> Next of Kin - Relationship _____	_____
<input type="checkbox"/> Responsible Party - Relationship (if different than above) _____	_____
<input type="checkbox"/> Law enforcement- (Specify) _____	_____
<input type="checkbox"/> Other (Specify) _____	_____

2) VICTIM/COMPLAINANT/SUBJECT OF REPORT [Check applicable box(es) Add address and phone if non-DHS person]

<input type="checkbox"/> Division Client	<input type="checkbox"/> Foster Child	<input type="checkbox"/> Client of Contract Agency	<input type="checkbox"/> Staff / Employee	<input type="checkbox"/> Other (Specify) _____
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NAME _____	DOB or AGE _____	RACE _____	GENDER _____
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3)

<u>Date of Incident</u>	<u>Time of Incident</u>	<u>Place of Incident</u>
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4) TYPE OF INCIDENT (With information available at time of report, check / complete all that seem applicable)

<input type="checkbox"/> Death ... Suspected Cause of Death _____
<input type="checkbox"/> Suicidal Behaviors
If checked, note date and results of clinical evaluation follow-up _____ <input type="checkbox"/> Pending
<input type="checkbox"/> Rape
<input type="checkbox"/> Maltreatment / Abuse / Exploitation
<input type="checkbox"/> Neglect <input type="checkbox"/> Verbal <input type="checkbox"/> Physical <input type="checkbox"/> Sexual <input type="checkbox"/> Other _____
<input type="checkbox"/> Injury
<input type="checkbox"/> Client <input type="checkbox"/> Staff <input type="checkbox"/> Public Extent & Intervention _____
<input type="checkbox"/> Missing Client (AWOL) (Report return of missing client as follow-up report)
<input type="checkbox"/> Disturbance
<input type="checkbox"/> Property Destruction Extent _____
<input type="checkbox"/> Theft – (to include Misappropriation of funds / property)
<input type="checkbox"/> Arrest
<input type="checkbox"/> Other _____

(Provided list not exhaustive; reference DHS Policy 1090)

5) DESIGNATION OF INCIDENT [Check applicable box(es)]

<input type="checkbox"/> Client-to-Client	<input type="checkbox"/> Client-to-Staff	<input type="checkbox"/> Self-Inflicted	<input type="checkbox"/> Staff-to-Client	<input type="checkbox"/> Client-to-Public	<input type="checkbox"/> Public-to-Client	<input type="checkbox"/> N/A
<input type="checkbox"/> Other (Specify) _____						

DHS-1910 (R.11/05) Incident Report form – for external providers; DHS to use IRIS

Attachment B - DHS Policy 1090

Page 1 of 2

6) ROLES (RELATIONSHIP TO SUBJECT) & NAMES OF OTHERS INVOLVED (Client, Staff, Witness, Participant, Perpetrator, etc.)
[Use separate line for each; Note all roles that apply per person, i.e. staff/participant, client/witness - identifiable abbreviations acceptable; Include addresses & phones of non-DHS persons; Use designated space at bottom of page to provide additional information as needed]

Role(s)	Name	Address & Phone <u>if non-DHS person</u>
Role(s)	Name	Address & Phone <u>if non-DHS person</u>
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7) CLEAR, CONCISE NARRATIVE DESCRIPTION (Include known essentials of who, what, when, where, why and how regarding incident)

8) SHOULD/COULD THIS INCIDENT HAVE BEEN PREVENTED/ANTICIPATED?

☐ YES

☐ NO

If yes, please explain

9) FINDINGS/OUTCOME/CASE DISPOSITION

(When appropriate, include Corrective Action or Preventive Plan for future)

☐ Pending Investigation

☐ Investigated with following plan/action

USE THE FOLLOWING SPACES TO PROVIDE ADDITIONAL INFORMATION AS NEEDED

[Please enter the number(s) of section(s) being referenced for clarity]

**DO NOT ATTACH ADDITIONAL DOCUMENTS: PROVIDER WILL BE CONTACTED FOR
ADDITIONAL INFORMATION IF NEEDED**

[EXCEPTION: CHILD DEATH FORM, CFS-329, TO BE SUBMITTED BY DCFS WITH DHS-1910 WHEN APPLICABLE]